| 2010 | | HMO-1 | HMO-4 (Available to Non-Represented and Library Employees Only) | POS-2 | |
|---|---|---|---|---|---|
| **Health Insurance Comparison Chart** | | 9% premium contribution monthly contribution amt | 3% premium contribution monthly contribution amt | 12% premium contribution monthly contribution amt | |
| | Single | $44.76 | $13.59 | $63.60 | |
| | Employee/Child | $82.49 | $25.05 | $117.21 | |
| | Employee/Spouse | $93.99 | $28.54 | $133.56 | |
| | Family | $144.79 | $43.97 | $205.74 | |
| | | | | In-Plan | Out-of-Plan |
| | Co-Pays | as listed below | as listed below | as listed below | |
| | Annual Deductibles | n/a | $250 individual/ $500 family | $250 individual/ $500 family | $500 individual/ $1000 family |
| | Co-Insurance | n/a | 20% of eligible expenses, unless otherwise specified | 10% of eligible expenses, unless otherwise specified | 30% of eligible expenses, unless otherwise specified |
| | Annual Out-of-Pocket Limit | n/a | $2000 individual/ $4000 family | $500 individual/ $1000 family | $1500 individual/ $3000 family |
| | | **This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage.** | | | |
| | | **HMO-1** | **HMO-4** | **POS-2** | |
| **Services** | | | | In-Plan | Out-of-Plan |
| **Wellness/ Preventive Health** | • Well Child Care Exams | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Periodic Physical Exams | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Immunizations | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Routine Mammography Services | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| **Physician and Practitioner Services** | **Primary Care Practitioner** | | | | |
| | • Office and Home visits | $10 Co-pay per visit | $20 Co-pay per visit | $15 Co-pay per visit | Deductible/Co-insurance |
| | • Inpatient visits | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | **Specialty Physician** | | | | |
| | • Office and Home visits | $10 Co-pay per visit | $20 Co-pay per visit | $15 Co-pay per visit | Deductible/Co-insurance |
| | • Routine Eye Exams *(limited to one per 12-month period)* | $10 Co-pay per visit | $20 Co-pay per visit | $15 Co-pay per visit | Deductible/Co-insurance |
| | • Chiropractic office visits and manipulations | $10 Co-pay per visit | $20 Co-pay per visit | $15 Co-pay per visit | Deductible/Co-insurance |

| | | This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage. | | | |
|---|---|---|---|---|---|
| | | **HMO-1** | **HMO-4** | **POS-2** | |
| **Services** | | | | In-Plan | Out-of-Plan |
| | • Allergy Immunizations | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Accidental Dental Services | No Charge | No Charge | No Charge | No Charge |
| | • Radiation/Chemotherapy Services | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Dialysis Services | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Surgery & Anesthesiology Services | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Routine Maternity (pre & post natal care) | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Inpatient visits | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Injectables administered in a Physician's office | *Please refer to your Prescription drug benefit levels* | *Please refer to your Prescription drug benefit levels* | *Please refer to your Prescription drug benefit levels* | *Please refer to your Prescription drug benefit levels* |
| **Diagnostic Services** | • X-Ray, Lab, Pathology *(practitioner's office or outpatient)* | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Diagnostic Mammography Services | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • PET Scans, MRI's, MRA's, CT Scans *(no coverage if not prior authorized)* | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Stress Tests | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Ultrasounds/Echocardiograms | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| **Hospital Services** | • Inpatient Hospital *(no coverage if not prior authorized)* | No Charge | Deductible/Co-insurance | Deductible/Co-insurance | Deductible/Co-insurance |
| | • Outpatient Services or Procedures *(including cardiac rehabilitation)* | No Charge | Deductible/Co-insurance | Deductible/Co-insurance | Deductible/Co-insurance |
| | • Ambulatory Surgical Center *(such as a colonoscopy)* | No Charge | Deductible/Co-insurance | Deductible/Co-insurance | Deductible/Co-insurance |
| **Rehabilitation Services** | • Therapy – Physical/Occupational/Speech | $10 Co-pay per visit | $20 Co-pay per visit | $15 Co-pay per visit | Deductible/Co-insurance |
| **Ambulance Services** | • Land and Air | No Charge | No Charge | No Charge | No Charge |
| **Home Health Care** | • Limited to 40 visits per 12-month period *(no coverage if not prior authorized)* | No Charge | No Charge | No Charge | Deductible/Co-insurance |

| | | This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage. | | | |
|---|---|---|---|---|---|
| | | **HMO-1** | **HMO-4** | **POS-2** | |
| **Services** | | | | In-Plan | Out-of-Plan |
| **Hospice Care** | *No Coverage if not prior authorized* | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| **Durable Medical Equipment** | • DME, Orthotics & Prosthetics<br>*(Prior authorization required for Durable Medical Equipment/Orthotics over $500 and prothetics over $1,000. No coverage if not prior authorized.)* | No Charge | Deductible/Co-insurance | Deductible/Co-insurance | Deductible/Co-insurance |
| **Diabetic Supplies** | *(Please refer to your Prescription Summary of Member Responsibility Table)* | | | | |
| **Medical Supplies** | Including insulin pump supplies | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| **Health Educational Programs** | *Please refer to the Certificate of Coverage for a list of benefits and limitations.* | No Charge | No Charge | No Charge | Not covered |
| **Behavioral Health** | Mental Health and Chemical Dependency Services<br>• Inpatient – Limited to 10 days per calendar year *(no coverage if not prior authorized)* | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Transitional – Limited to 20 days per calendar year | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| | • Outpatient – Limited to 20 visits per calendar year | No Charge | No Charge | No Charge | Deductible/Co-insurance |
| **Emergency/Urgent Care** *(Emergency room or hospital based urgent care facility)* | • Emergency Room Services *(co-pay waived if admitted inpatient within 24 hours)* | $50 Co-pay per visit | $50 Co-pay per visit | $50 co-pay per visit | $50 co-pay per visit |
| | • Urgent Care | $10 Co-pay per visit | $20 Co-pay per visit | $15 Co-pay per visit | Deductible/Co-insurance |
| **Maximum Policy Benefit** | | $5,000,000 per Member per Lifetime | $5,000,000 per Member per Lifetime | $5,000,000 per Member per Lifetime | |

| | | This comparison chart is not a guarantee of coverage, please refer to the Certificate of Coverage, and Riders for detailed benefit information restrictions, limitations and exclusions that apply to that coverage. | | | |
|---|---|---|---|---|---|
| | | **HMO-1** | **HMO-4** | **POS-2** | |
| **Services** | | | | In-Plan | Out-of-Plan |
| **Prescription** | | Retail Pharmacy:<br>$10/25/50/50/80 co-pay<br><br>Mail Order Pharmacy:<br>$25/60/150 co-pay | Retail Pharmacy:<br>$10/25/50/50/80 co-pay<br><br>Mail Order Pharmacy:<br>$25/60/150 co-pay | Retail Pharmacy: $10/25/50/50/80 co-pay<br><br>Mail Order Pharmacy: $25/60/150 co-pay | |